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## Protocol for Culturally Responsive Organizations: Literature Review and Standards for Performance

Marie-Elena Reyes  
*Portland State University*

Ann Curry-Stevens  
*Portland State University, currya@pdx.edu*

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# PROTOCOL FOR CULTURALLY RESPONSIVE ORGANIZATIONS

Literature Review and Standards for Performance

Marie-Elena Reyes  
Ann Curry-Stevens

Center to Advance Racial Equity  
Portland State University

***Thank you to our funders!***



**Contact Information**

Center to Advance Racial Equity  
Ann Curry-Stevens, Founding Director  
1800 SW 6<sup>th</sup> Avenue, Suite 600  
Portland, OR 97201

Tel. (503) 725-5315

Email: [currya@pdx.edu](mailto:currya@pdx.edu)

Website: [www.centertoadvanceracialequity.org](http://www.centertoadvanceracialequity.org)

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## Introduction to the Protocol and Its Component Parts

At the request of the Coalition of Communities of Color, the Center to Advance Racial Equity (CARE) was asked to assist in the development of a Protocol for Culturally Responsive Organizations (also called the Protocol) that it would use to improve the quality of services available to communities of color in mainstream health and human services. To achieve this, we have researched the literature available that provides evidence of the effectiveness of various interventions. Priority has been given to the literatures on culturally-responsive service delivery (which has been thin) and culturally-competent services (which while abundantly written about, relatively little exists that has provided convincing evidence of its effectiveness). Research has been primarily conducted in the field of health services, with fewer articles that are research based from the fields of child welfare, parent skills training and a few in other places.

The research studies have primarily determined success in cultural responsiveness in two areas: improvement of health conditions or presenting problems, and client satisfaction with services. Fewer still have confirmed successful outcomes in a pre- and post-intervention situation, with the majority looking retrospectively on the ways in which service users value the interventions. The “thinness” of this overall literature of evidence has led us to review at considerable depth the existing protocols, standards, and guides that have been developed for this work and for related work in the national arena and state level. These supplemental resources have helped us in the development of the reference grid for the protocol.

Within this document are definitions of cultural responsiveness and cultural competence, the literature review itself, a summary of the ways the emerging substance for the Protocol aligns with the research literature, and the two most relevant sets of standards: the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care, 2013 (also called CLAS) and the Culturally Responsive Framework, 2009 (also called CALD or ‘cultural and linguistic diversity.’

The “Protocol for Culturally Responsive Organizations” is now available at the following online location, available for free downloading: <http://www.centertoadvanceracialequity.org/publications/> .

## Definitions of Cultural Responsiveness & Cultural Competency

Definitions	
<p>The literature on cultural competence is vast and contains numerous definitions for cultural competence and related elements. However the number of literature references defining the terms “cultural responsiveness” or “culturally responsive” is minimal and two of those references are included below. Most often the terms “cultural responsiveness” or “culturally responsive” have been defined in relation to delivery of culturally competent services.</p>	
Reference	Definition
<p>Rural and Regional Health and Aged Care Services. (2009). <i>Cultural Responsiveness Framework: Guidelines for Victorian Health Services</i>. Victorian Government, Melbourne. of Victoria, Department of Health.</p>	<p><b>Cultural responsiveness</b> refers to health care services that are respectful of, and relevant to, the health beliefs, health practices, culture and linguistic needs of diverse consumer/patient populations and communities. That is, communities whose members identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home. Cultural responsiveness describes the capacity to respond to the healthcare issues of diverse communities. It thus requires knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual. (p. 12)</p> <p><b>Cultural competence</b> A set of congruent behaviors, attitudes and policies that come together in a system or agency or among professionals that enable that system, agency or those professionals to work effectively in cross-cultural situations (Cross, et al., 1989).</p>
<p>Department of Health, (2009). <i>Review of Current Cultural and Linguistic Diversity and Cultural Competence Reporting Requirements, Minimum Standards and Benchmarks for Victoria Health Services Project: Final Report</i>. Statewide Quality Branch, Victorian Government, Melbourne</p>	<p>(Same working definitions as in report above with the following additional framework definitions (p. 26)):</p> <p><b>Organizational cultural competence:</b> This involves reflection of racial and ethnic diversity in health care leadership and work force. Inclusion of community members in health care process and formally including community health advocates and recruiting staff from diverse communities would enhance cultural competence in the organization.</p> <p><b>Systemic cultural competence:</b> Systemic barriers such as a lack of interpreter services, culturally and linguistically appropriate health education materials can lead to patient dissatisfaction, poor comprehensive and compliance, and lower quality care.</p> <p><b>Clinical cultural competence:</b> The role of cross-cultural education and training including education in cultural competence for senior management, health services, and staff is vital in the provision of quality care. The focus of training should be on: socioeconomic factors. Communication skills, and mechanisms for addressing racism and bias. Patient empowerment is also a source of cultural competence.</p>
<p>Mindell, R., Vidal de Haymes, M., and Francisco, D. (2003). <i>A Culturally Responsive Practice Model for Urban Indian Child Welfare Services</i>. <i>Child Welfare</i> 82(2): 201-217.</p>	<p><b>Culturally responsive guiding principles:</b> Accessibility/Flexibility, Community Empowerment and Participation, Recognition of Urban Indian Culture and History, Bridge the Gap Between Legal and Social Work Practice in Indian Child Welfare, Use the Benefits of University, Community, and Child Welfare System Partnerships.</p>
<p>Cross, T., Bazron, B., Dennis, K., &amp; Isaacs, M., (1989). <i>Towards A Culturally Competent System of Care Volume I</i>. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center. Department of Health, (2009).</p>	<p><b>Cultural competence:</b> a set if congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations.</p>

<p>National Quality Forum (NQF) (2009). <i>A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency: A Consensus Report</i>. Washington, DC: NQF.</p>	<p><b>Cultural competency</b> is the ongoing capacity of healthcare systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable.</p>
<p>Betancourt, J. R. (2006). <i>Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care</i>. New York: The Commonwealth Fund.</p>	<p><b>Cultural competency:</b> developing an understanding of the patient communities being served, as well as individual patients' health beliefs and behaviors, considering how these factors interact with the health care system in ways that may prevent diverse populations from obtaining quality health care; and devising strategies to effectively address and monitor them through several interventions.</p> <p><b>Organizational cultural competence:</b> increasing the diversity of the health care workforce and leadership. Organizational capacities, such as diversity in the leadership of health care delivery systems (including the board of trustees and senior management), diversity of staff and providers (including provider networks), and strategies for diversity in all hiring practices and recruitment, are critical.</p> <p><b>Systemic cultural competence:</b> conducting community assessments and developing mechanisms for feedback; implementing collection of data on race/ethnicity and language preference; monitoring patient satisfaction by race/ethnicity; and ensuring culturally appropriate health education materials, signage, interpretation services, and health promotion and disease prevention interventions.</p> <p><b>Clinical cultural competence:</b> using training and education to raise providers' awareness of how sociocultural factors affect health beliefs and behaviors; empowering patients to take active roles in medical encounters; improving communication across cultures; building trust between providers and patients, and between patients and the health system; and being attentive to the effects of race, ethnicity, and culture on clinical decision-making.</p>
<p>Goode, T. D., Dunne, M. C., and Bronheim, S. M., (2006). <i>The Evidence Base for Cultural and Linguistic Competency in Health Care</i>. New York: The Commonwealth Fund.</p>	<p><b>Cultural competence</b> requires that organizations: - Have a defined, congruent set of values and principles, and demonstrate behaviors, attitudes, policies, and structures that enable them and their personnel to work effectively cross-culturally; - Have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, and adapt to diversity and the cultural contexts of the communities they serve; - Incorporate the above in all aspects of policymaking, administration, practice, and service delivery, and systematically involve patients, families, and their communities.</p>
<p>DHS Diversity Development and Coordinating Council (DDCC) (2003). <i>DHS Standards and Guidelines for Cultural Competency and Gender Specific Services</i>. Oregon Department of Human Services.</p>	<p><b>Cultural competence</b> refers to the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, disabilities, religions, genders, sexual orientation and other diversity factors in a manner that recognizes, affirms, and values the worth of individuals, families and communities and protects and preserves the dignity of each. Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes.</p>
<p>Gilmer, R., Tillman, T., and Wang, E. (2013). <i>Cultural Competence Continuing Education Committee Recommendations for Advancing Cultural Competence Continuing Education for Health Professionals in Oregon</i>.</p>	<p><b>Cultural Competence:</b> A life-long process of examining values and beliefs, of developing and applying an inclusive approach to health care practice in a manner that recognizes the context and complexities of provider-patient interactions and preserves the dignity of individuals, families and communities. This process is applicable to all patients; assumptions will not be made on the basis of a person's expressed or perceived race, color, spiritual beliefs, creed,</p>

	<p>age, tribal affiliation, national origin, immigration or refugee status, marital status, socio-economic status, veteran’s status, sexual orientation, gender identity, gender expression, and gender transition, level of formal education, physical or mental disability, medical condition or any other consideration under federal, state and local law. The term “cultural” is used here in its broadest sense as “the totality of a person’s or a group’s accumulated experience”, and the term “competency” is defined as the “ability to do something well.” Based on this document’s definition of cultural competency, it would mean to adequately engage in the lifelong process or self-examination, inclusivity, awareness and respect in health care practice in accordance to the principles and standards below.</p>
<p>Office of Minority Health, U.S. Department of Health and Human Services. (2001). National Standards for Culturally and Linguistically Appropriate Services in Health Care: FINAL REPORT.</p>	<p><b>Cultural and linguistic competence</b> is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations. ‘Culture’ refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. ‘Competence’ implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities” (Based on Cross, et al., (1989).</p>
<p>National Center for Cultural Competence (NCCC), Georgetown University</p>	<p><b>Cultural competence</b> requires that organizations:</p> <ul style="list-style-type: none"> <li>• have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally.</li> <li>• have the capacity to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge and (5) adapt to diversity and the cultural contexts of the communities they serve.</li> <li>• incorporate the above in all aspects of policy making, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.</li> </ul> <p>Cultural competence is a developmental process that evolves over an extended period. Both individuals and organizations are at various levels of awareness, knowledge and skills along the cultural competence continuum. (adapted from Cross et al., 1989).</p>



## Organizational commitment, leadership and governance

In the field of health and human services, there is little written about the importance of organizational leadership that documents – in research contexts – its role in culturally-responsive organizations. That said, there is an abundance of such content in the tools and advisory checklists on its importance, dating back to the original work on cultural competency established by Terry Cross and his colleagues (1989). There is, however, expansive literature on the importance of top leadership commitment from the field of diversity and equity management, primarily documented within the private sector and its efforts to embrace diversity. In this field, a leading study of 32 companies was conducted internationally (ORC Worldwide, 2008).

The key findings show that strong equity and inclusion performance is correlated with the following factors:

- Public values statements include diversity and inclusion (rather than generic values statements)
- CEO is held accountable for progress to the Board of Directors and compensation is tied to progress
- The Board is racially diverse
- The Board considers its own recruitment through a diversity lens
- CEO demands his/her executives to report on diversity progress, and “holds them accountable for both their personal behavior and for meeting objectives such as developing and mentoring diverse people” (p.2)
- Managers are trained in identifying and avoiding micro-aggressions.

This follows a study from DiversityInc (2009) of 11 CEOs and 100 chief diversity officers identified the following for creating inclusive workplaces:

- “Ensure that your CEO and leadership team are visible supporters of diversity and inclusion initiatives
- Integrate diversity into every aspect of your business... “(p.4)
- “Ensure your diversity and inclusion efforts also engage and equip white men to be a part of the dialogue and the effort” (p.5)
- “Incorporate standards for inclusive behavior into the performance-review process
- Directly link bonus to measurable results including recruitment, retention, promotion and supplier diversity” (p.6)
- “Help create a vibrant, sustainable pipeline of future employee candidates by supporting and developing initiatives that bolster the academic pipeline” (p.7)

A third study of twenty-one health care sites on their practices were measures against what the authors identify as “gold standard” levels of cultural competency (Seigel, Haugland & Chambers, 2003). Given the authors’ use of institutional practices such as governance and infusion of cultural competency across the organization, the work is much more aligned with that of this report – the framework of culturally responsive organizations. They worked with an expert panel of twelve national leaders with extensive experience as cultural competency experts in health who established a key set of twelve domains and 42 indicators that were believed essential for rooting cultural competency across an organization. The domains in their approach are the following:

- Commitment of organization to cultural competence
- Integration of cultural competence within the organization
- Activities related to cultural competence in organizational components

- Cultural competence advisory committee
- Knowledge of cultural needs of target population/population area
- Knowledge of cultural needs of service users
- Linguistic capacity
- Services
- Cultural competence training and education
- Recruitment, hiring and retention
- Outcomes (which is really a measure of data systems to identify outcomes)
- Consumer and family education

Making explicit connections to this section on leadership and governance, we find in this article affirms that equity needs to be embedded at the top of the organization, and for an equity-based committee to report to the executive level of the organization's administration.

### **Racial equity policies and implementation practices**

The literature in health and human services rarely speaks of the policy dimensions of cultural competence (and this is why the literature and related interventions do not reach far enough into systems change work). That does not stop the health care field from advocating an array of policy and implementation practices that are contained in this report. Numerous examples of cultural responsiveness standards and cultural competency guidelines (in an array of published documents included in the bibliography of this report) integrate racial equity policies and procedural requirements – the likes of which are contained in this Protocol – but the evidence base as typically established through research has not yet caught up with the sensibilities of leaders in the field.

Foundations such as the Burns Institute, Robert Wood Johnson and the Annie E. Case Foundation have been funding racial equity initiatives at the institutional level for about a decade, in efforts to address racial disparities in systems such as child welfare and juvenile justice to eliminate the pervasive problem of youth of color being overrepresented in foster care and in confinement. It is in this literature that we find abundant references to the importance of racial equity policies. The goals of such policies is three-fold: to ensure that progress is not etched back when leadership changes; to make a clear and direct commitment of intention to advance racial equity; and to establish within the text clearly lines of accountability for the effectiveness of the policy.

In the area of systems change work that is typically incorporated within health and human services, we find that there are a set of reform elements that are beginning to consolidate around vision and policy, data systems, training, human resource improvements, budgeting, service-based practice competencies, community engagement and accountability structures. In child welfare disparity reduction efforts the following have emerged (drawing from Texas Department of Human Services, 2013 and from Annie E. Casey):

- Accurate data systems
- Leadership development
- Culturally-competent workforce
- Community engagement

- Cross-systems collaboration (with those serving the same population)
- Building awareness of the histories of racism, racial dynamics and strategies to undo racism.

There are a growing number of organizations that are embarking on similar change strategies to address disproportionality. Another leading organization is the Burns Institute, and their platform for addressing disparities includes the following: building political will, comprehensive assessment of data on sites of disparities, and of organizational decision points at which disparities emerge, recruiting (or developing) staff with the skills to be transparent, accountable and knowing alternatives to implement, and with an environment that is committed to racial equity in the long haul, as opposed to an approach that suggests a quick fix.

## Organizational climate, culture and communications

While climate is a challenging element to both research and to modify, it can be tied to a set of policies, vision and practice that can promote inclusion and acceptance of communities of color. This work has been led within the education system, where the National School Climate Center (2009) has been at the foreground of creating standards. Its work is based on case studies, dialogues with school leaders and surveys of parents and students. While not conducted in the context of health and human services, translation to these systems appears appropriate. Their guidelines emphasize the policy context to ensure that desired outcomes are measurable, inclusive and direction-setting, and include the following:

- Develop a shared vision and plan for promoting, enhancing and sustaining a positive school climate
- Develop policies that promote social, emotional, ethical, civic and intellectual learning as well as systems that address barriers to learning
- Promote practices that promote the learning and positive social, emotional, ethical and civic development of students and student engagement as well as addressing barriers to learning
- Create an environment where all members are welcomed, supported, and feel safe in school: socially, emotionally, intellectually and physically
- Develop meaningful and engaging practices, activities and norms that promote social and civic responsibilities and a commitment to social justice (p.3, National School Climate Center, 2009).

## Service-Based Equity

### Sub-Domain 1: Workers have knowledge of community

Recommendations for culturally competent and responsive care have highlighted the necessity for health care workers to have knowledge of the communities served. It is essential that health care workers understand the history, policy experiences, local culture, disparities, and priorities for reform to be responsive to health needs of the community being served and to provide the most effective health care. O'Brien, Boddy, & Hardy (2007) emphasize the need for nurses to understand cultural needs of Maori patients in New Zealand to adequately address the disproportionate rates of mental illness among the New Zealand Maori population.

The need for the same-gender provider, translated written materials, not addressing a woman by her first name, recuperating at home rather than in a hospital were all reported as preferences among the Hmong community to insure the best health care was provided (Parker & Kiatoukaysy, 1999). Considering how to integrate Western medicine with the prevalent use of traditional medicines and healers within the Hmong and other ethnic communities would help to build trust with the clients and may improve compliance. Parker & Kiatoukaysy (1999) state that face-to-face encounters with the physician and the interpreter are vital to create trusting relationships which are highly valued within the Hmong community.

In Starr County, Texas, a culturally competent diabetes intervention employed bilingual nurses, dieticians, and community workers (diagnosed with diabetes) from the Mexican American community to educate clients about diabetes self-management (Brown, Garcia, Kouzekanani, & Hanis, 2002). Diabetes health outcomes and diabetes knowledge were significantly greater for treatment participants (n=128) than control group individuals (n=128) over the year of the intervention. The authors identified additional mitigating factors, increasing their knowledge of community, through support sessions with clients that potentially impacted outcomes such as access to free monitoring equipment, economic difficulties with acquiring foods for dietary changes, and safety issues when exercising outside of home (from crime and extreme temperatures).

Individuals with diabetes were selected from a Mexican-American community and trained as promotoras (lay health educators) to lead diabetes education intervention classes for Project Dulce (Phillis-Tsimikas, Fortmann, Lleva-Ocana, Walker, & Gallo, 2011). Although diabetes outcome indicators improved significantly for the treatment participants (n=104) over control participants (n=103) during the 10-month intervention, the researchers cautioned that longer-term studies would be needed to assess if life-style changes were sustained and continued to improve health outcomes.

A domestic violence agency serving an African American women survivors developed a culturally specific program (Gillum, 2008) which included hiring mostly African American staff; curriculum imbued with African American culture, history, lifestyles, experiences; and an Afrocentric environment within the agency office. Clients (n=14) identified the African American staff, curriculum, environment and holistic approaches as important for their own healing as well as beneficial for all of the African American community. Some clients reported that the agency's environment helped them to feel welcome and as though the services had been developed especially for them.

Trained workers/advocates recruited from within the Native American community were paired with non-native case managers to provide cultural knowledge and expertise for Native American child welfare cases in Illinois (Mindell et al., 2003). The authors described a community/agency/academic collaboration that resulted in recruiting from the community being served, development of Native American social workers, and an advocates training program. However no information was provided about the number of participants who: graduated from the training program, were assigned to work with agency non-native case managers, or the impact of provided client services.

Case studies of several programs providing services for homelessness among Aboriginal communities in Canada were the subject of a report on culturally responsive approaches (McCallum et al., 2011). Interviewed staff emphasized the importance of "knowing cultural ways rather than cultural facts" including understanding

the “names, histories, and politics of local bands” for developing trust. For clients, working with Aboriginal staff meant “one less cultural barrier to overcome in the healing process” and staff that were more capable of supporting residents cultural/spiritual needs. At Kootenay Lodge, which employed both Aboriginal (and non-Aboriginal) staff, all employees were required to attend a day of Aboriginal Awareness led by Elders. Finally, report recommendations included embedding elders and ceremony into the organizational structure of community service agencies, developing processes for evaluation of culturally responsive services and promoting partnerships between Aboriginal and non-Aboriginal organizations to expand access to funding, resources, and expertise.

### **Sub-Domain 2: Self-Knowledge of Biases and Differences**

Anderson et al. (2003) reviewed the literature on culturally competent healthcare systems between 1965 and 2001, including goals to “enhance self-awareness of attitudes toward people of different racial and ethnic groups” in providers (an indicator of effective cultural competency training). The authors found only one relevant study and determined that there was too little evidence to assess effectiveness of the intervention with providers. Since that earlier review, few additional studies have reported on interventions, which focused on self-knowledge of biases and differences for health care providers.

Paez et al. (2008) explored the relationship between culturally competent providers (n=49) and the clinics in which they work (23 clinics). The Cultural Competence Assessment Instrument (CCA) was used to measure the implicit attitudes (unconscious biases) toward race and ethnicity based on actual behaviors as self-reported by participating providers. Although only one third of the providers had attended cultural competency training, over half were confident in their treatment of diverse and underprivileged patients. Providers who were more confident treating ethnically diverse patients practiced behaviors linked to an understanding of white privilege. The researchers found that providers working in culturally competent settings (clinic had adopted CLAS standards) were more likely to have culturally competent attitudes and behaviors. How or if the findings were used to inform provider or clinic practices was not discussed.

Self-reporting methodology was used to assess knowledge and self-awareness attitudinal changes with pediatric students participating in a culturally effective health care curriculum (Paul et al., 2008). Researchers found that self-reporting methods were not effective for assessing attitudinal changes following culturally competent training as students reported higher gains in knowledge and culturally competent attitudes than was actually observed by supervisors in clinical settings.

New research is emerging that illustrates that personal biases can be unlearned and prejudice reduced through a combination of motivators, with the most productive motivators being those that tap into the values of inclusion, prejudice reduction and an emphasis on counter-narratives that emphasize the contributions and capacities of communities of color. The use of reprimands and controls are not supported in research by Lai et al (2013) as they found that such controls can actually backfire. Unfortunately, the social experimental design by Lai et al was not able to assess the workplace environment where a combination of counter-narratives, affirmations of the values of inclusion, as well as policies and accountability standards would be possible. In related research, Legault et al (2011) were able to confirm the benefits of leadership who articulate the benefits of inclusion and prejudice reduction, the benefits of checks and balances to guide decision making

(and diffuse the influence of bias and prejudice), and an overall environment of asset-based valuing of those with marginal identities.

A final piece of research reminds us that changing behavior – with the goal of eliminating disparities – needs to be understood in the larger context of wider society and the larger policy landscape. Snowden and Yamada (2005) conducted a meta-analysis of research on overcoming barriers to care, but were unable to conclude the “correct” pathways toward racial equity. They affirmed some key ingredients for reducing disparities, emphasizing flexibility in services to adjust to differing cultural contexts was essential (such as home visits, multifamily group therapy as opposed to individual families, self-guided videos for skills training, providing transportation, child care and low therapy costs. But they concluded their work by stating that more research was needed in the area of non-specialized supports, expanded trustworthiness, elimination of stigma, accommodation of cultural beliefs, and styles of expression of suffering. They also emphasize that the larger policy context is important as it determines funding levels for services, and dominant forms of treatment.

### **Sub-Domain 3: Language accessibility for service users**

Language accessibility has been discussed by patients (Garrett, Dickson, Lis-Young, Whelan, & Roberto-Forero, 2008) and researchers as important for providing culturally competent/responsive, and effective health care (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Brach & Fraser, 2000; Parker & Kiatoukaysy, 1999). Brach and Fraserirector (2000) presented a thorough discussion of associations between language accessibility and potential improvements in patient health outcomes. The authors reported that patient satisfaction was impacted by the quality of interpretation. Patients attended by language-concordant physicians reported more satisfaction than those who communicated through “ad hoc” interpreters. A review of culturally competent interventions for Hispanic adults with Type 2 diabetes included eleven studies which provided Spanish language components, bilingual staff, and translation as needed (Whittemore, 2007). A majority of the studies reviewed by Whittemore, reported significant improvements for participants “in select clinical outcomes, behavioral outcomes and diabetes-related knowledge”.

Patients who were attended by language-discordant physicians were more likely to omit medication, miss appointments, and be less satisfied with their health care. Flores et al. (2000) reported on three case studies from the Latino community which highlighted the problems of misunderstandings, missed information, and misdiagnosis due to language barriers and a lack of knowledge about the culture of the patients being served. Due to the absence of an interpreter or a language-concordant provider, the critical condition of a child was not diagnosed (during two previous visits) until after her appendix had perforated and the family returned to the emergency room. A child abuse report was submitted in a second case study due to a misunderstanding about how a child’s injuries had occurred when no interpreter was available. Flores et al. discuss language issues and lack of knowledge in normative cultural values that resulted in “inferior quality of care, adverse outcomes, increased health care costs, and parental dissatisfaction.”

Anderson et al (2003) reviewed a study (Sarver & Baker, 2000) that compared bilingual providers and interpreter services to see which would result in the desired outcome of follow-up appointments. Language-concordant providers were significantly more likely to recommend follow-up appointments for their patients than providers attending patients who conversed through an interpreter or patients who were in need of an

interpreter but didn't use one. However participants of the intervention were not more likely than controls to attend the appointments.

Latinos participating in an parent training intervention for Child Parent Relationship Theory (CPRT) methods reported the following culturally responsive factors as important for their participation: 1) having classes and materials, training sessions, group meetings, and evaluation interviews conducted in Spanish; 2) childcare being provided; and 3) working with a facilitator (a Latina immigrant) who reflected the community and understood participant concerns (Ceballos & Bratton, 2010). Wu & Martinez (2006) reported a similar finding from a National Initiative for Children's Healthcare Quality (NICHQ) project which provided interpreters resulting in "better communications, more appropriate diagnosis, and a deeper understanding of patient needs".

#### **Sub-Domain 4: Health literacy issues**

The impacts of parent training in Child Parent Relationship Theory (CPRT) methods was the subject of a small intervention study (n= 48) with immigrant Latino parents (Ceballos & Bratton, 2010) Latino parents were trained to use play therapy (adapted for Latino populations and translated into Spanish) with their own children (a filial approach) previously shown (with non-Latino groups) to facilitate a child's cognitive and social development. Ceballos & Bratton concluded that the intervention strengthened the bond between parent and child thereby lessening parent-child relational stress (for 62.5% of participating parents) and related child behavioral problems (in 85% of children of participating parents).

A smoking cessation study included 243 African-American smokers randomly assigned to one of four treatment groups to explore the impacts of culturally specific smoking-related messages on the health of smokers (Webb, Baker, & Rodriguez de Ybarra, 2010) Culturally specific messages included historical, sociocultural, environmental, and psychological factors such as discussions of slavery and smoking, targeted tobacco marketing, specific health consequences for African American smokers, and well-known African Americans who had died from smoking related diseases. Researchers found that culturally specific messages on smoking cessation and exercise, influenced risk perceptions, intentions to quit, and smoking-related knowledge for African-American participants.

Mexican American diet preferences were included in a culturally competent intervention to promote education and self-management of diabetes (Brown, Garcia, Kouzekanani, et al., 2002; Brown, Garcia, & Winchell, 2002; Brown & Hanis, 1999). The intervention was implemented over 12 months through bi-lingual Mexican American health care nurses, dieticians, and community workers in a study which included 256 Mexican American diabetes patients. Half of the participants received the treatment during the 12 month period and the other half (the control group) were provided the intervention following the termination of the study. Significant changes were found in three health indicators for diabetes self-management.

Diabetes self-management education was also the focus of Project Dulce with Mexican Americans. Researchers (Phillis-Tsimikas et al., 2011) designed a randomized clinical trial with half of the participants (n=104) and assigned the other half of participants (n=103) to the control group (no treatment). Treatment participants received Spanish language curriculum, training, materials, and peer-educator (Promotoras)

support groups over 10 months. The treatment participants showed significant improvements in diabetes health indicators over time.

## Service user voice and influence

Various researchers have investigated service user voice by gathering perceptions of quality care services that are described as culturally competent/culturally sensitive/culturally responsive presumably to inform models, frameworks, and practices that better serve their increasingly diverse service users. Papers chosen for this domain included disaggregated data for race and/or ethnic group and shed light on the elements of quality care considered important. Studies often included small numbers of participants but contained rich information about how service users define quality care. Although themes were identified for service users from specific ethnic groups, authors warned of extrapolating to other service users, as results were specific to the site, methodology, community, and condition/need.

In some cases service users' perspectives have been gathered to validate assessment tools for quality care (Bagchi et al., 2012; Carolyn M. Tucker et al., 2007). In other cases the results informed further research for model, intervention, and tool development (Fongwa, Sayre, & Anderson, 2008; Garrett et al., 2008). In a few instances the results were used to guide enhancements to practice, environment, and service delivery (Mindell et al., 2003; Waites, Macgowan, Pennell, Carlton-LaNey, & Weil, 2004; Wu & Martinez, 2006). Conversely, patient perspectives were collected in at least two studies as a way for providers to learn about cultural or traditional practices that were not conveyed in a typical office visit and considered harmful by the provider. For example, Philis-Tsimikas (2011) used interactive discussion sessions to learn about traditional healing practices of some Mexican patients which providers think may interfere with provider recommendations.

Beresford's work (2001) on service user voice in the context of social policy formation amplifies the importance of service users' perspectives in both macro and institutional policy. Simultaneously, Beresford cautions the professionals who interpret and report such experiences. While macro social work practice is essential to addressing downstream distress, the lens of power and voice causes a hefty and important critique to be aimed at the policy practitioners who have not adequately represented the needs of service users and welfare recipients. Policy practice without "full and equal involvement of service users" (p.509) will fail in both substance and praxis.

A ten-year initiative in public welfare services in Jerusalem, Israel, serving 40,000 households sought to transform service users' influence over the services and discourses in which they were served. Interventions included intervention methods, integration of advocacy, and service user voice. Gains were made in client-validated definitions of problems, respectful recognition, freedom from judgment, egalitarian approaches to working with clients, client satisfaction with services, and a shift towards group and community practices. Outcomes in improved client life circumstances did not result, causing the authors to assert that transformation was limited by neo-liberal and neo-managerial policies and discourses.



### **Sub-Domain 1: Validation of Assessment Instruments**

Bagchi et al. (2012) reported on a qualitative study assessing cultural differences in perceptions of health care quality. Racial/ethnic-affinity focus groups watched a film of an encounter between an elderly Asian Indian female patient and white male doctor. Focus groups of African American, Latino, Asian Indian, and White patients (n=84) were asked to rate the quality of health care received in the film. Facilitators led focus group discussions with questions adapted from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and CAHPS supplemental surveys, widely used for assessing health care services. Of the 35 concepts/themes identified in the focus group discussions, sixteen new concepts/themes emerged from focus group discussions. Concepts most frequently mentioned by all groups as important for quality health care were 1) waiting times, 2) patient-provider communication, 3) a doctor's technical skills, and 4) a doctor's respect for the patient (wait times were associated with respect by all patients of color). For African Americans, wait time, rapport, respect and listening ability were mentioned most often. Latinos mentioned wait time, rapport, expertise, and health concerns most often. Differences in culture, gender, and age were often discussed in racial/ethnic groups (but not by White patients) as potential barriers to communication. A Latino group member discussed the importance of the physician learning about the culture of his patients and increasing diversity among office staff. For an Asian Indian participant, respecting traditional beliefs and practices of patients was important. Holistic approaches (physical, spiritual, emotional needs of patients) were cited as important by all except White participants. Authors concluded that focus group discussions revealed cultural group differences in perceptions of quality health care as well as pointing to weaknesses in the survey tool to adequately measure racial/ethnic perspectives.

Tucker et al. (2007) developed a tool to evaluate cultural sensitivity of staff, providers, environmental characteristics of community care centers through the use of focus groups. African-American, Hispanic, and non-Hispanic White service users were asked about positive personal qualities of health care providers, trust-building behaviors, culturally sensitive and respectful behaviors, clinic environment, and other factors important to the service users. Emerging themes were used to develop 3 race/ethnicity-specific Health Care Importance Rating Survey (HIRS) forms. HIRS were then administered to other low-income patients recruited from each of the three racial and ethnic groupings for validation of the instrument. Themes from the focus groups and HIRS were then used to create a tool called the Tucker Culturally Sensitive Health Care Inventories (T-CUSHCIs).

### **Sub-Domain 2: Model, Intervention, and Tool Development**

Quality of health care themes were identified from databases of gender-specific and ethnic-affinity focus group interviews (n=127), with African Americans, Latinos and White service users (Fongwa et al., 2008). Follow up surveys were designed using themes identified from the database analysis (resulting in ethnic specific surveys). Then focus group participants were recruited to rate survey themes as markers for quality of care. Nine themes were considered important across the 3 ethnic groups. Also identified in the study were themes uniquely important for each group. Authors did not include rankings of themes within ethnic group. Themes listed as important for African-Americans included being honest, elderly support, knowledge of health care system, societal position, and trust. For Latinos themes included language, family, trust providers, being nice/kindness, and patients are grateful/ patient satisfaction. Whites felt that important themes included elderly support, many young people being uninsured, cultural beliefs about quality, personalized care and

waiting time, and proximity of healthcare setting location. Authors offered findings as useful information for “facilitating culturally competent caring” processes and practices.

Garrett et al. (2008) conducted a qualitative study, with non-English speaking participants (49 patients and 10 “carers”) from seven language-specific focus groups to discuss health care experiences and what they value about health care. Key concerns expressed by participants included language barriers, inattention to cultural mores, and racism. Service users valued positive engagement, information and involvement in health care decisions, compassionate and respectful treatment, and family involvement in care. The researchers reported competencies and example practices for: facilitating language; negotiating family involvement; understanding patient beliefs, expectations, experiences and constructions; being compassionate and respecting patient and human rights. Authors recommended that rather than viewing cultural competency as a static set of skills and attributes that are ethnicity based, the cultural competency concepts would be best used as a template that was constantly updated through “compassionate negotiation and discussion between patients and healthcare providers.”

### **Sub-Domain 3: Enhancements to Practice, Environment, and Service Delivery**

A Native American community group in Chicago initiated discussions with a state agency to develop a culturally responsive model for delivering child welfare services. Focus groups, co-facilitated by academic, agency and community groups, were held to identify what child welfare professionals needed to know to serve the Native American community in Chicago (Mindell et al., 2003). Focus groups included Native American elders, community leaders, foster parents, advocates, and adults who had been in the foster care system. Perspectives gained were used to inform curriculum development for training staff at the state child welfare agency.

Waites et al. (2004) sought “cultural guidance” to assess and adapt family group conferencing (developed in New Zealand for serving Aboriginal service users) as a culturally responsive service in child welfare cases with African American, Latinos/Hispanics, and non-Hispanic White communities in North Carolina. The researchers used focus groups comprised of professionals, service providers, lay community members, and service users to explore important themes for these groups. Among African-Americans, physical and social environment and effective communication emerged as most important, while among Latinos/Hispanics language was most important. Among non-Hispanic whites, effective communication and building a collaborative relationship were most important. Authors acknowledged that rather than gaining a common service model to use with all ethnic groups, the process for engaging community members was unique to each ethnic group and important for acceptance.

The Wu and Martinez Commonwealth Fund report (2006) cited an exemplary practice of engaging with community beginning at the planning steps for new projects. Planning for a new community clinic brought together architects, tribal elders, and health providers to discuss “What does the community need for wellness?” Recommendations for modeling buildings after traditional Native American homes of the local community were incorporated into the building design of a new community clinic center.

Two studies focused on different sectors of the African American community. Although similar themes resonated with both sectors (i.e. respect and sensitivity to patient's beliefs, attitudes, and practices) each

study elicited distinctive responses. Service users (14 women) of a domestic violence agency, receiving culturally specific services (to the African American community) identified the following services as important: a family centered approach, a prayer/spirituality/spiritually based approach, services designed specifically for African Americans, African American staff, Afrocentric curriculum and environment, and a holistic approach (Gillum, 2008). A second study of a focus group with 23 African Americans (men and women) over 39 years old were engaged in open-ended discussions and a questionnaire to determine how patients defined cultural competency (Johnson, Slusar, Chaatre, & Johnsen, 2006). Patient definitions of "high quality care" from a physician included respectful and individual treatment, availability, accessibility, effective communication, knowledge of race and culture, and concern for their well-being. Some important attributes expressed by the participants in the second study, as missing in their health service experiences were: sensitivity to patient's beliefs, attitudes, and practices, information about health care resources, and medications.

*Project Dulce*, a culturally based intervention with interactive classes inspired by the Promotora model (community health care liaisons) closely followed participants of Mexican descent with diabetes education and interactive classes (Philis-Tsimikas et al., 2011). Participants shared experiences and beliefs of diabetes in a peer-education intervention study to reduce cultural barriers for health services and education. It is unclear if any recommendations based on patient shared experiences and beliefs were incorporated into the study design or clinic practices. Seemingly deficit model terminology such as "myths, beliefs and cultural remedies that may interfere with the adoption of health recommendations" was used to preface that such practices needed to be corrected through health education. Attitudes like this seem to directly contradict the perspectives of having health care providers who are knowledgeable and respectful about the cultures they serve considered important by many ethnic groups.

## Workforce Composition & Quality

Workforce composition and quality recommendations have been described as critical elements for achieving cultural competence and for delivering culturally responsive care (Betancourt, 2006; Betancourt, Green, Carrillo, & Park, 2005; Delphin-Rittmon, Andres-Hyman, Flanagan, & Davidson, 2013; Wu & Martinez, 2006). Staff that reflects the local community are considered essential for connecting with service users/patients from the community. This priority is reflected in the Office of Minority Health CLAS Standard #3 (2013). Culturally competent staff may provide: cross-cultural communication, language interpretation, an understanding of cultural beliefs and values, and a trusting and welcoming atmosphere for service users/patients. CLAS Standard #4 recommends continuous staff training in cultural competency to foster a workforce that is knowledgeable and guided by “culturally and linguistically appropriate policies and practices”. Culturally responsive services (adopted in Australia) embody a “capacity to respond to the healthcare issues of diverse communities” and require “knowledge and capacity at different levels of intervention: systemic, organizational, professional and individual” (2009)

### Sub-Domain 1: Workforce composition

Reference to workforce composition has been noted tangentially in studies, which included staff representative of the ethnic group being served. One example was the bilingual group facilitator, a Latina immigrant and doctoral-level student experienced in parent training of the Child Parent Relationship Theory (CPRT) methods with low-income, immigrant Latino parents of children exhibiting behavioral problems (Ceballos & Bratton, 2010). A Commonwealth Fund report (Goode, Dunne, & Bronheim, 2006) cited three diabetes intervention studies which included representative ethnic staff; 1) a diabetes intervention which employed bilingual Mexican American providers from the community (Brown & Hanis, 1999); 2) a study which included race-concordant providers working with African American women with diabetes (D'Eramo-Melkus 2004),; and 3) a study which included bilingual/bicultural providers and peer educators (Promotoras) from same cultural and ethnic group as the service users (Gilmer, Philis-Tsimikas, & Walker, 2005). None of these four studies discussed assessment of the impacts when including community representative providers.

Gillum’s paper (2008) of a culturally specific domestic violence agency serving African American survivors cited that a majority of staff members were African American and representative of the clients served. All clients interviewed found this helpful because they “related better to African American staff” and because of the employment opportunities being provided to their community.

The Latin American Cancer Research Coalition (LASRC) (Kreling et al., 2006) found that gender, ethnic, and language matching of community clinic staff to service users was important for recruiting Latino subjects to participate in their clinical research.

Interviews with 22 service providers from large urban centers and case studies were collected from Aboriginal Housing Providers in Western Canada, that demonstrated culturally responsive shelter and support services for Aboriginal peoples (McCallum, Isaac, & Centre for Native Policy and Research Social Planning, 2011). All of the Aboriginal Housing Providers cited had employed Aboriginal staff as they were considered more capable of supporting residents’ cultural/spiritual needs and in hopes of reducing at least one cultural barrier “to overcome in the healing process”.

## Sub-Domain 2: Workforce Training

The Chief Executive Officer of a California medical center reported that her organization linked cultural competency to patient safety and service and that cultural competency training was "built into" staff orientation, ongoing training, job descriptions, policies, and procedures (Wu & Martinez, 2006). Similarly Hassett (2005) reported that Aetna provided for required cultural competency training for 1500 doctors, nurses, and clinical professionals - Quality Interactions Program. However the authors do not provide any details about the cultural competency training or assessment of training and its impact on service users.

In case studies of culturally responsive Aboriginal Housing Providers in Western Canada (McCallum et al., 2011), Aboriginal Awareness training was provided for all staff by Elders and additional community members to create a common foundation of cultural understanding among all staff.

In another culturally responsive practice model delivering child welfare services (Mindell, Vidal de Haymes, & Francisco, 2003), a training curriculum was developed and evaluated in collaboration with the Native American Foster Parent Association (NAFPA) from the local community being served. Workers/Advocates were recruited from within the Native American community and intensively trained on Indian Child Welfare Act (ICWA) as child welfare specialists (scholarships were provided for training). Advocates (under the supervision by a licensed social worker, LCSW) would assess whether cases were compliant with ICWA and that services being provided were culturally responsive. The Worker/Advocate acted as a resource to service users and the non-Native caseworker or agency by gathering information on the service user's tribal affiliation, traditional values, beliefs, traditions, and rituals as well as facilitating tribal reunification of children and families.

Clinician teams (46 physicians and 16 physician's assistants or nurse practitioners) participated in trainings that highlighted racial disparities in diabetes care, appropriate methods for collecting culturally relevant data, and ways to incorporate that data into effective clinical care plans for diabetics (Sequist et al., 2010). Participating clinicians cared for 2699 black and 4858 white patients. Monthly performance feedback and educational materials were provided to the clinicians during the year-long intervention. Performance feedback reports included race-stratified prescribing patterns; that is, racial differences in the number of care recommendations existed even after clinicians were advised of the expressed need for health care information from significantly higher numbers of black patients (among 1,084 surveyed diabetic patients). Educational materials included themes for quality care (gathered through race-specific focus groups and surveys of diabetic patients) and recommended strategies for better serving black patients. Clinician teams who participated in the 12-month intervention were more likely to acknowledge racial disparities in the care, information, and prescriptions given to diabetic patients. It is important to note that only half of the participating primary care physicians from the clinician teams attended the initial cultural competency training and this may be linked to the result that this intervention had no significant impact in the care of black patients. Although all clinician teams received monthly performance feedback and educational materials as recommended by Betancourt (2006), this cultural competence intervention did not result in improved care or health for black patients during the 12-month intervention period.

The training focus for a community/academic coalition on cancer research (LACRC; (Kreling et al., 2006) was on cancer control and reducing health care disparities in Latino populations. Training was developed for community primary care staff, university students who did outreach to community, and Latino and other

researchers working to reduce disparities in Latino populations. During the first four years of the project, cancer control coordinators were trained by LACRC for each of 6 community clinic partner sites. Fifty-nine undergraduate minority student interns and community staff were trained in social marketing for cancer control in Latino populations. Pilot interventions at participating clinics were collaborative projects developed and delivered by the experienced researchers with Latino clinic partners. As mentioned earlier, trained service providers and researchers representative of the community being served were important for recruiting a traditionally underrepresented population (Latinos) for cancer interventions. Post LACRC training reviews of medical charts showed mixed impacts on provider recommendations and performance of cancer screenings over pre-intervention rates. Specifically there were increased rates for mammography and pap screening tests but not for colorectal screenings.

Pediatric third-year students (n=22) were required to participate in culturally effective curriculum and instruction during their clerkship at a community hospital (Paul, Devries, Fliegel, Van Cleave, & Kish, 2008). Faculty at the same site underwent training with the developed curriculum to facilitate modeling of the culturally effective strategies with service users. Curriculum units focused on folk illness history (including use of homemade remedies) and language/communication (including gender and modesty concerns). Assessment of curriculum intervention was based on knowledge of folk illness and language issues and found that knowledge was higher for students at this site compared to others from comparable sites who had not participated in curriculum intervention.

## **Community Collaborations**

A review of the literature for examples of community collaborations expressly for advancing culturally competent and responsive practices yielded only a few examples.

The Illinois Department of Children & Family Services and local Native American Foster Parent Group (became NAFPA); collaboratively developed training and linkage and referral services for child welfare staff, recruitment of Native foster homes, and tribal enrollment services (Mindell et al., 2003)

Concerns over high obesity rates in children from an orthodox Jewish community in Chicago motivated community members to request participation in a culturally appropriate school health program study (Benjamins & Whitman, 2010). A culturally relevant intervention was developed and supervised by a steering committee of health and school organizations from the local Jewish community. Students (n=581) from grades 1-8 participated in the 2-year pilot study to address obesity through education, physical activity, and behavioral changes for students, family and school staff. Participation in study required that a wellness council be formed and the writing of a wellness policy. Results = nutritional knowledge of younger girls and both older boys and girls increased; physical activity increased to 1 hour or more on most days after intervention for older students.

A Midwestern School of Nursing received a grant to increase cultural competence of students through improved graduate curricula. Collaboration of university faculty with community members was called the

Nursing and Culture project. Meetings over 3 months of community members (representing 19 different community-based organizations), 11 university faculty, and 2 nursing students resulted in curricular recommendations about student competencies in self-awareness, basic knowledge of culture and identity, attitudes that promote intercultural communication, cross-cultural clinical skills, and advocacy skills.

Perhaps one of the most extensive examples of community collaborations is that of the Latin American Cancer Research Coalition (LACRC), which was an academic/community clinic collaboration designed to control cancer among typically understudied Latino communities. An advisory board composed of local community leaders shared oversight of the project along with the Steering Committee (Kreling et al., 2006). LACRC conducted a needs assessment with community, patients, providers, and LACRC advisors to understand the perceived cancer control priorities and concerns. Priorities that emerged from the needs assessment were then used to direct research activities (8 pilot interventions) designed and carried out by teams of primary care community clinic providers, local hospitals, and academic researchers. Additionally LACRC trained cancer control coordinators for each of the 6 partner community clinics. Latino student interns and community clinic staff were trained in social marketing for Latino populations. LACRC researchers reported three important lessons: 1) that gender, ethnic, and language matching of research staff to subjects was central for recruiting Latinos for intervention participation; 2) that the creation and maintenance of trusting community relationships were critical for service delivery and program success; and 3) the cultural competency of the researchers (both academic and clinic providers) were enhanced by collaborations with community partners and advocacy organizations.

Finally, Aboriginal homelessness programs in multiple Canadian urban areas, described by McCallum and Issac (2011), embody culturally responsive services and were developed in consultation with the local Aboriginal communities. For instance, the Aboriginal Health and Wellness Center of Winnipeg was designed in response to expressed needs within community forums and Elder Circles for a blending of both Traditional and Western approaches for healing. Cultural and spiritual activities, Aboriginal staff, community involvement, and community capacity building are considered important elements of the culturally responsive programs described by McCallum and Issac (2011).

Completing this section, we return to the work of Beresford and Croft (2001) who build – from an experiential and theoretical position – the key role that service users and their communities must take in configuring services and the elements of service provision. Their text emphasizes the rights, demands, and preferences of poor people (and other service users) to determine the nature and needs of the organizations and systems that serve them. Service users need to be active participants in policy, practice, and analysis rather than passive recipients. More collective user-led and user-controlled alternatives to services and research practices are advocated so as to simultaneously limit the undue power of professional service providers, while enhancing the influence of the community over the provision of service. Embedded in the authors' approach is the call for awareness of the privilege of the service provider and a pervasive troubling of this positionality, particularly when the impacts of inadequate services are not borne by the provider or his/her community.

## Data Metrics & Continuous Quality Improvements

Goode et al. (2006) described a culturally and linguistically competent organization as a system that would result in increases of: satisfaction for patients and providers, mutual respect and shared decision making, effective communication, and health indicators that determine the effectiveness of interventions. The authors found that culturally competent intervention studies were generally in early stages and measured a limited number of outcomes, such as, increased use of screening, improved treatment compliance, health indicators (e.g. blood glucose levels), or recommended lifestyle changes. Data metrics have been developed to report on the effectiveness of service providers, client satisfaction, health outcomes of patients, client desires from a culturally competent system such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS). Validation of the instruments is ongoing and the reported analyses have been mixed. Exactly how the data collected had been applied to service provision, policy, or practice was not described in the literature reviewed.

Weech-Maldonado et al. (2012a; 2012b) reported on the validation study of organizational assessment survey tools including CAHPS, Cultural Competency Assessment Tool for Hospitals (CCATH), the National CAHPS Benchmarking Database (NCBD), and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). The CCATH was based on the U.S. Department of Health and Human Services' Office of Minority Health CLAS standards (Office of Minority U.S. Department of Health and Human Services, 2013) and the National Quality Forum's (NQF) benchmarks. Weech-Maldonado et al. analyzed responses of 19,583 patients from 66 hospitals and found that hospitals with greater cultural competency were rated higher in patient satisfaction. The authors noted that impact of cultural competency extended to additional dimensions such as communication, staff responsiveness, and pain control and was greater for "minority" patients. However a smaller study of the widely used CAHPS survey with 84 participants from ethnically diverse groups (Bagchi, Af Ursin, & Leonard, 2012) found that CAHPS failed to capture the perspectives of an ethnically diverse populations of quality health care or culturally competent services.

Weidmer-Ocampo et al. (2009) adapted the CAHPS for an American Indian population served by the Choctaw Nation Health Services (CNHS). The survey was developed in consultation with CNHS and approved by the Choctaw Nation Tribal Council and Chief. The adapted survey was field-tested through mailings and 696 surveys were returned yielding a strong 58% response rate and providing information for quality improvement.

Tools for obtaining patient feedback on culturally sensitive healthcare received at community clinics were developed for African-American, Hispanic, and non-Hispanic white patients (C. M. Tucker et al., 2007). Initially 221 patients were asked to rate the importance of ethnically-derived elements of "patient-centered culturally sensitive healthcare". The Tucker-Culturally Sensitive Health Care Inventory (T-CUSHCI) ethnic-specific pilot inventory forms for were then constructed and tested with an additional 179 African American and non-Hispanic white patients from local clinics (the sample size of Hispanic patients participating in the second round of testing were too small to be included in the results). Rank ordering of most important elements for African American and Hispanic patients (as compared to non-Hispanic white patients) were: 1) provider comfort, trust, and respect behaviors and attitudes; 2) office staff behaviors and attitudes; and 3) the center policies and physical environment characteristics.



Development of a 2-factor construct (Cultural Congruence) to assess the impact of culturally competent services in mental health delivery was the subject of a study by Costantino, Malgady, & Primavera (2009). Cultural Congruence (CC) was defined as the difference or distance between the cultural competence of the healthcare provider organization (SCC) and the cultural “neediness” of the client (CNN); that is, Cultural Competence = Service Cultural Competence – Client Cultural Need. Briefly, if the client’s needs were greater than the culturally competent services provided by the organization, CC would be negative. Conversely if the clinic had more cultural resources than the client needed the CC would be positive. The participating Hispanic/Latino clients (n=272) were mostly first generation, older adult (65-92 years old) immigrants from 3 different study sites and were randomly assigned to the treatment or control group. The researchers found that cultural congruence was significantly related to a reduction of depression and anxiety symptoms and positively correlated to physical functioning, vitality, mental health, social functioning, and general mental health. In summary, a reduction in depression and anxiety accompanied by improvements in physical, social, and mental health outcomes was more likely for participants receiving culturally competent treatment (i.e. culturally competent resources exceeded patient needs). Costantino, Malgady, & Primavera caution that the metric must be replicated with various ages, racial and ethnic, and diagnostic groups to determine its validity.

## Appendix A: Standards and Benchmarks Resources

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## Appendix C: Synthesis of Literature Organized According to CLAS & CALD Standards

Standards for Culturally Responsive Framework (CALD) <sup>1</sup>	Standard	Sub-Measures	Literature
<b>Domain 1. Organizational Effectiveness</b>	<u>Standard 1.</u> A whole of organization approach to cultural responsiveness is demonstrated.		
	<u>Standard 2.</u> Leadership for cultural responsiveness is demonstrated by the health service.		
<b>Domain 2. Risk Management</b>	<u>Standard 3.</u> Accredited interpreters are provided to patients who require one.	Implementation of the Department of Human Services Language service Policy	Patient satisfaction was impacted by the quality of interpretation (higher satisfaction with language concordant physicians). <sup>2</sup> A majority of studies reviewed by Whittemore reported significant improvements for participants “in select clinical outcomes, behavioral outcomes and diabetes-related knowledge”. National Initiative for Children’s Healthcare Quality (NICHQ) project provided interpreters resulting in “better communications, more appropriate diagnosis, and a deeper understanding of patient needs”.
<b>Domain 3. Consumer Participation</b>	<u>Standard 4.</u> Inclusive practice in care planning is demonstrated, including but not limited to: dietary, spiritual, family, attitudinal and other cultural practices	Feedback from patients on the provision of information about their care and treatment is used to inform planning development and review of services and support	Perspectives gained from focus groups (including Native American elders, community leaders, foster parents, advocates, and adults who had been in the foster care system) were used to inform curriculum development for training staff at a state child welfare agency. <sup>3</sup>
			Researchers used focus groups comprised of professionals, service providers, lay community members, and service users to explore important themes in family conferencing for African-Americans, Latinos/Hispanics, and non-Hispanic whites. Authors emphasized that rather than gaining a common service model to use with all ethnic groups, the process for engaging community members was unique to each ethnic group and important for acceptance. <sup>4</sup>
		CALD patient satisfaction data collected and analyzed (VPSM and other)	

Standards for Culturally Responsive Framework (CALD) <sup>1</sup>	Standard	Sub-Measures	Literature
		Consumer evaluation of cultural appropriateness of particular programs or services	Planning for a new community clinic brought together architects, tribal elders, and health providers to discuss “What does the community need for wellness?” Recommendations for modeling buildings after traditional Native American homes of the local community were incorporated into the building design of a new community clinic center. <sup>5</sup>
			The Aboriginal Health and Wellness Center of Winnipeg was designed in response to expressed needs within community forums and Elder Circles for a blending of both Traditional and Western approaches for healing. Cultural and spiritual activities, Aboriginal staff, community involvement, and community capacity building are considered important elements of the culturally responsive programs described. <sup>6</sup>
		Development or use of suitable instruments for assessment (clinical diagnosis and treatment), incorporating cultural considerations used by medical, clinical and allied health staff	Racial/ethnic-affinity focus groups watched a film of an encounter between an elderly Asian Indian female patient and white male doctor and were asked to rate the quality of health care received in the film. Facilitators led focus group discussions with questions adapted from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and CAHPS supplemental surveys, widely used for assessing health care services. Focus group discussions revealed cultural group differences in perceptions of quality health care as well as pointing to weaknesses in the survey tool to adequately measure racial/ethnic perspectives. <sup>7</sup>
			The Cultural Competency Assessment Tool for Hospitals (CCATH) was based on the U.S. Department of Health and Human Services’ Office of Minority Health CLAS standards (Office of Minority U.S. Department of Health and Human Services, 2013) and the National Quality Forum’s (NQF) benchmarks. Responses of 19,583 patients from 66 hospitals were analyzed. Hospitals with greater cultural competency were rated higher in patient satisfaction. <sup>8</sup> The authors noted that impact of cultural competency extended to additional dimensions such as communication, staff responsiveness, and pain control and was greater for “minority” patients. However a smaller study of the widely used CAHPS survey with 84 participants from ethnically diverse groups found that CAHPS failed to capture the perspectives of ethnically diverse populations of quality health care or culturally competent services. <sup>7</sup>
			The CAHPS was adapted for an American Indian population served by the Choctaw Nation Health Services (CNHS) in consultation with CNHS and approved by the Choctaw Nation Tribal Council and Chief. The adapted survey was field-tested through mailings and 696 surveys were returned yielding a strong 58% response rate and providing information for quality improvement. <sup>9</sup>
			Tools for obtaining patient feedback on culturally sensitive healthcare received at community clinics were developed for African-American, Hispanic, and non-Hispanic white patients. <sup>10</sup> Initially 221 patients were asked to rate the importance of

Standards for Culturally Responsive Framework (CALD) <sup>1</sup>	Standard	Sub-Measures	Literature
			ethnically-derived elements of “patient-centered culturally sensitive healthcare”. The Tucker-Culturally Sensitive Health Care Inventory (T-CUSHCI) ethnic-specific pilot inventory forms for were then constructed and tested with an additional 179 African American and non-Hispanic white patients from local clinics (the sample size of Hispanic patients participating in the second round of testing were too small to be included in the results). Rank ordering of most important elements for African American and Hispanic patients (as compared to non-Hispanic white patients) were: 1) provider comfort, trust, and respect behaviors and attitudes; 2) office staff behaviors and attitudes; and 3) the center policies and physical environment characteristics.
			Development of a 2-factor construct (Cultural Congruence) to assess the impact of culturally competent services in mental health delivery was the subject of a study. <sup>11</sup> A reduction in depression and anxiety accompanied by improvements in physical, social, and mental health outcomes were more likely for participants receiving culturally competent treatment (i.e. culturally competent resources exceeded patient needs). Researchers caution that the metric must be replicated with various ages, racial and ethnic, and diagnostic groups to determine its validity.
	<u>Standard 5.</u> CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis	Minutes of meetings show that the CAC/CDC or other specified structure has provided advice on planning and evaluation to the Board (CAC) or Executive (CDC) of the health service	
		CALD consumer and stakeholder involvement in performance review and quality improvement processes	A tool to evaluate cultural sensitivity of staff, providers, and environmental characteristics of community care centers was validated through the use of focus groups. <sup>10</sup> African-American, Hispanic, and non-Hispanic White service users were asked about positive personal qualities of health care providers, trust-building behaviors, culturally sensitive and respectful behaviors, clinic environment, and other factors important to the service users. Emerging themes were used to develop 3 race/ethnicity-specific Health Care Importance Rating Survey (HIRS) forms. HIRS were then administered to other low-income patients recruited from each of the three racial and ethnic groupings for validation of the instrument. Themes from the focus groups and HIRS were then used to create a tool called the Tucker Culturally Sensitive Health Care Inventories (T-CUSHCIs).

Standards for Culturally Responsive Framework (CALD) <sup>1</sup>	Standard	Sub-Measures	Literature
			Ethnic specific surveys were designed using themes identified from the database analysis of gender-specific and ethnic-affinity focus group interviews. Then focus group participants (African Americans, Latinos and White service users) were recruited to rate survey themes as markers for quality of care. Nine themes considered important across the 3 ethnic groups, in addition to themes uniquely important for each group were reported. Authors offered findings as useful information for “facilitating culturally competent caring” processes and practices. <sup>12</sup>
			A qualitative study was conducted with non-English speaking participants (49 patients and 10 “carers”) from seven language-specific focus groups to discuss health care experiences and what they value about health care. Key concerns and valued service characteristics were expressed by service users. Authors recommended that rather than viewing cultural competency as a static set of skills and attributes that are ethnicity based, the cultural competency concepts would be best used as a template that was constantly updated through "compassionate negotiation and discussion between patients and healthcare providers". <sup>13</sup>
		Policies in place for facilitation of different degrees of participation from CALD consumers	
<b>Domain 4. Effective Workforce</b>	Standard 6. Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness	Budget allocation for culturally responsive workforce development	
		Training opportunities for staff (i.e. admissions, reception, clinical staff, management, executive) on: 1) provisions of language services and use of interpreters (at commencement of employment, as part of orientation program); 2) culturally responsive service delivery strategies; 3) conducting	Clinician teams who participated in a 12-month intervention highlighting racial disparities in diabetes care, appropriate methods for collecting culturally relevant data, and ways to incorporate that data into effective clinical care plans for diabetics were more likely to acknowledge racial disparities in the care, information, and prescriptions given to diabetic patients. It is important to note that only half of the participating primary care physicians from the clinician teams attended the initial cultural competency training and this may be linked to the result that this intervention had no significant impact in the care of black patients. Although all clinician teams received monthly performance feedback and educational materials as recommended by others, this cultural competence intervention did not result in improved care or health for black patients during the 12-month intervention period. <sup>14</sup>

Standards for Culturally Responsive Framework (CALD) <sup>1</sup>	Standard	Sub-Measures	Literature
		cultural assessments to understand consumer/patient's explanatory model for illness.	
			Trained service providers and researchers representative of the community being served were important for recruiting a traditionally underrepresented population (Latinos) for cancer interventions. Post training reviews of medical charts showed mixed impacts on provider recommendations and performance of cancer screenings over pre-intervention rates. Specifically there were increased rates for mammography and pap screening tests but not for colorectal screenings. <sup>15</sup>
			The Chief Executive Officer of a California medical center reported that her organization linked cultural competency to patient safety and service and that cultural competency training was "built into" staff orientation, ongoing training, job descriptions, policies, and procedures. <sup>5</sup> Similarly Aetna provided for required cultural competency training for 1500 doctors, nurses, and clinical professionals - Quality Interactions Program. However the authors do not provide any details about the cultural competency training or assessment of training and its impact on service users. <sup>16</sup>
		Demonstrated post training staff evaluation on effectiveness and application of professional development	The Cultural Competence Assessment Instrument (CCA) was used to measure the implicit attitudes (unconscious biases) toward race and ethnicity based on actual behaviors as self-reported by participating providers. Although only one third of the providers had attended cultural competency training, over half were confident in their treatment of diverse and underprivileged patients. Providers who were more confident treating ethnically diverse patients practiced behaviors linked to an understanding of white privilege. The researchers found that providers working in culturally competent settings (clinic had adopted CLAS standards) were more likely to have culturally competent attitudes and behaviors. How or if the findings were used to the inform provider or clinic practices was not discussed. <sup>17</sup>
			Self-reporting methodology was used to assess knowledge and self-awareness attitudinal changes with pediatric students participating in a culturally effective health care curriculum. Self-reporting methods were not effective for assessing attitudinal changes following culturally competent training as students reported higher gains in knowledge and culturally competent attitudes than was actually observed by supervisors in clinical settings. <sup>18</sup>
		HR process and practices include cultural	

Standards for Culturally Responsive Framework (CALD) <sup>1</sup>	Standard	Sub-Measures	Literature
		<p>responsiveness  references in position descriptions,  performance review and promotion.</p>	
		<p>Internal communication systems for sharing cultural diversity information and data are developed, maintained and periodically reviewed.</p>	

National Standards for Culturally and Linguistically Appropriate Services (CLAS) <sup>19</sup>	Relevant Research Literature
1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.	
2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.	
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.	A bilingual Latina immigrant and doctoral-level student experienced in parent training of the Child Parent Relationship Theory (CPRT) methods, worked with low-income, immigrant Latino parents of children exhibiting behavioral problems <sup>20</sup> . A Commonwealth Fund report <sup>21</sup> cited three diabetes intervention studies that included representative ethnic staff but did not discuss assessment of impacts when including community representative providers.
	A culturally specific domestic violence agency serving African American survivors reported that a majority of staff members were African American and representative of the clients served. All clients interviewed found this helpful because they “related better to African American staff” and because of the employment opportunities being provided to their community <sup>22</sup>
	The Latin American Cancer Research Coalition (LASRC) <sup>23</sup> found that gender, ethnic, and language matching of comm staff to service users was important for recruiting Latino subjects to participate in their clinical research.
	Aboriginal Housing Providers in Western Canada, employed Aboriginal staff considered more capable of supporting residents’ cultural/spiritual needs and in hopes of reducing at least one cultural barrier “to overcome in the healing process” <sup>24</sup> .
	In case studies of culturally responsive Aboriginal Housing Providers in Western Canada, Aboriginal Awareness training was provided for all staff by Elders and additional community members to create a common foundation of cultural understanding among all staff. <sup>24</sup>
	Worker/Advocates were recruited from within the Native American community and intensively trained on Indian Child Welfare Act (ICWA) as child welfare specialists (scholarships were provided for training). Advocates (under the supervision by a licensed social worker, LCSW) would assess whether cases were compliant with ICWA and that services being provided were culturally responsive. The Worker/Advocate acted as a resource to service users and the non-Native caseworker or agency by gathering information on the service user’s tribal affiliation, traditional values, beliefs, traditions, and rituals as well as facilitating tribal reunification of children and families. <sup>25</sup>
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.	Clinician teams who participated in a 12-month intervention highlighting racial disparities in diabetes care, appropriate methods for collecting culturally relevant data, and ways to incorporate that data into effective clinical care plans for diabetics <sup>26</sup> were more likely to acknowledge racial disparities in the care, information, and prescriptions given to diabetic patients. It is important to note that only half of the participating primary care physicians from the clinician teams attended the initial cultural competency training and this may be linked to the result that this intervention had no significant impact in the care of black patients. Although all clinician teams

National Standards for Culturally and Linguistically Appropriate Services (CLAS) <sup>19</sup>	Relevant Research Literature
	received monthly performance feedback and educational materials, this cultural competence intervention did not result in improved care or health for black patients during the 12-month intervention period.
	Trained service providers and researchers representative of the community being served were important for recruiting a traditionally underrepresented population (Latinos) for cancer interventions. Post training reviews of medical charts showed mixed impacts on provider recommendations and performance of cancer screenings over pre-intervention rates. Specifically there were increased rates for mammography and pap screening tests but not for colorectal screenings. <sup>23</sup>
	Pediatric third-year students (n=22) were required to participate in culturally effective curriculum and instruction during their clerkship at a community hospital. <sup>27</sup> Faculty at the same site underwent training with the developed curriculum to facilitate modeling of the culturally effective strategies. Assessment of curriculum intervention found that knowledge was higher for students at this site compared to others from comparable sites.
5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.	Patient satisfaction was impacted by the quality of interpretation (higher satisfaction with language concordant physicians). <sup>28</sup> A majority of studies reviewed by Whittemore reported significant improvements for participants "in select clinical outcomes, behavioral outcomes and diabetes-related knowledge". National Initiative for Children's Healthcare Quality (NICHQ) project provided interpreters resulting in "better communications, more appropriate diagnosis, and a deeper understanding of patient needs".
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.	
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.	
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.	Latinos participating in an parent training intervention for Child Parent Relationship Theory (CPRT) methods reported having classes and materials, training sessions, group meetings, and evaluation interviews conducted in Spanish as important for their participation <sup>20</sup>
9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.	
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.	
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.	
12. Conduct regular assessments of community health assets and needs and use the results to plan and	Perspectives gained from focus groups (including Native American elders, community leaders, foster parents, advocates, and adults who had been in the foster care system) were used to inform curriculum development for training staff at a state child welfare agency. <sup>25</sup>



National Standards for Culturally and Linguistically Appropriate Services (CLAS) <sup>19</sup>	Relevant Research Literature
implement services that respond to the cultural and linguistic diversity of populations in the service area.	
	Researchers used focus groups comprised of professionals, service providers, lay community members, and service users to explore important themes in family conferencing for African-Americans, Latinos/Hispanics, and non-Hispanic whites. Authors emphasized that rather than gaining a common service model to use with all ethnic groups, the process for engaging community members was unique to each ethnic group and important for acceptance. <sup>29</sup>
	Planning for a new community clinic brought together architects, tribal elders, and health providers to discuss “What does the community need for wellness?” Recommendations for modeling buildings after traditional Native American homes of the local community were incorporated into the building design of a new community clinic center. <sup>30</sup>
	Racial/ethnic-affinity focus groups watched a film of an encounter between an elderly Asian Indian female patient and white male doctor and were asked to rate the quality of health care received in the film. Facilitators led focus group discussions with questions adapted from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and CAHPS supplemental surveys, widely used for assessing health care services. Focus group discussions revealed cultural group differences in perceptions of quality health care as well as pointing to weaknesses in the survey tool to adequately measure racial/ethnic perspectives. <sup>31</sup>
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.	A tool was developed to evaluate cultural sensitivity of staff, providers, and environmental characteristics of community care centers through the use of focus groups. African-American, Hispanic, and non-Hispanic White service users were asked about positive personal qualities of health care providers, trust-building behaviors, culturally sensitive and respectful behaviors, clinic environment, and other factors important to the service users. Emerging themes were used to develop 3 race/ethnicity-specific Health Care Importance Rating Survey (HIRS) forms. HIRS were then administered to other low-income patients recruited from each of the three racial and ethnic groupings for validation of the instrument. Themes from the focus groups and HIRS were then used to create a tool called the Tucker Culturally Sensitive Health Care Inventories (T-CUSHCIs). <sup>32</sup>
	Ethnic specific surveys were designed using themes identified from the database analysis of gender-specific and ethnic-affinity focus group interviews. Then focus group participants (African Americans, Latinos and White service users) were recruited to rate survey themes as markers for quality of care. Nine themes considered important across the 3 ethnic groups, in addition to themes uniquely important for each group were reported. Authors offered findings as useful information for “facilitating culturally competent caring” processes and practices. <sup>33</sup>
	Garrett et al. <sup>34</sup> conducted a qualitative study, with non-English speaking participants (49 patients and 10 “carers”) from seven language-specific focus groups to discuss health care experiences and what they value about health care. Key concerns and valued service characteristics were expressed by service users. Authors recommended that rather than viewing cultural competency as a static set of skills and attributes that are ethnicity based, the cultural competency concepts would be best used as a template that was constantly updated through "compassionate negotiation and discussion between patients and healthcare providers".

National Standards for Culturally and Linguistically Appropriate Services (CLAS) <sup>19</sup>	Relevant Research Literature
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.	
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.	

## Appendix D: National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (2013)

These standards were adopted in 2000 as “recommended national standards for adoption or adaptation by stakeholder organizations and agencies.” Updated in 2013, the summary report states that, “state agencies have embraced the importance of cultural and linguistic competency in the decade since the initial publication of the National CLAS Standards. A number of states have proposed or passed legislation pertaining to cultural competency training for one or more segments of their state’s health professionals. At least six states have moved to mandate some form of cultural and linguistic competency for either all or a component of its health care workforce.”

The opening of the CLAS standards text defines the rationale for these standards and the key motivation that led to their development:

“As the U.S. population becomes more diverse, medical providers and other people involved in health care delivery are interacting with patients/consumers from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how health care services are delivered and received, it is important that health care organizations and their staff understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse patients/consumers bring to the health encounter. Providing culturally and linguistically appropriate services (CLAS) to these patients has the potential to improve access to care, quality of care, and, ultimately, health outcomes.

Unfortunately, a lack of comprehensive standards has left organizations and providers with no clear guidance on how to provide CLAS in health care settings. In 1997, the Office of Minority Health (OMH) undertook the development of national standards to provide a much-needed alternative to the current patchwork of independently developed definitions, practices, and requirements concerning CLAS. The Office initiated a project to develop recommended national CLAS standards that would support a more consistent and comprehensive approach to cultural and linguistic competence in health care.”<sup>35</sup>

These National CLAS Standards<sup>36</sup> are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

### **Principal Standard:**

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

### **Governance, Leadership, and Workforce:**

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.

3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.

4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

**Communication and Language Assistance:**

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

**Engagement, Continuous Improvement, and Accountability:**

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

## Appendix E: Cultural Responsiveness Framework: Guidelines for Victorian Health Services (CALD)

These standards, measures and sub-measures have been reproduced from the original version for succinctness. The citation for the full document is available in Appendix A.<sup>37</sup>

### **Standard 1: A whole-of-organisation approach to cultural responsiveness is demonstrated**

#### **Measure 1**

The following four policies, guidelines and processes are implemented:

- The health service has developed and is implementing a Cultural responsiveness plan (CRP) that addresses the six standards of the framework
- Reporting on the cultural responsiveness standards in the health services' *Quality of care report*
- A functioning Community Advisory Committee (CAC), Cultural Diversity Committee (CDC), or other structure demonstrating CALD participation and input
- Implementation of the Department of Human Services *Language services policy*.

#### **Sub-Measures**

- Organisational guidelines and protocols that guide staff in working with CALD communities, consumers and carers.
- Allocation and specification of financial resources for cultural responsiveness.
- Development of appropriate information technologies and strategies for data collection, reporting and sharing information on cultural responsiveness.
- Monitoring of community profile and changing demographics supported by employment of relevant in-house interpreters, appropriate translations and signage.
- Partnerships with multicultural and ethno-specific community organisations in the area/region are developed and maintained.

### **Standard 2: Leadership for cultural responsiveness is demonstrated by the health service**

#### **Measure 2.1**

Numerator: The number of senior managers who have undertaken leadership training for cultural responsiveness

Denominator: The total number of senior managers

#### **Sub-measures**

- An executive staff member has portfolio responsibility for cultural responsiveness and Key Performance Indicators (KPIs) against the Cultural responsiveness plan.
- Employment of a cultural diversity staff member where 20% or more of health service patients are of CALD background.
- Research opportunities are identified and undertaken to develop new and improved initiatives and resources for cultural responsiveness.
- Training opportunities for senior managers on:
  - culturally responsive service delivery strategies
  - conducting organisational cultural assessments/audits.

### **Standard 3: Accredited interpreters are provided to patients who require one**

### **Measure 3.1**

- Numerator: Number of CALD consumers/patients identified as requiring an interpreter and who receive accredited interpreter services
- Denominator: Number of CALD consumers/patients presenting at the health service identified as requiring interpreter services

### **Measure 3.212**

- Numerator: Number of community languages used in translated materials and resources
- Denominator: Total number of community language groups accessing the service

#### **Sub-measures**

- Implementation of the Department of Human Services *Language services policy*.
- Documentation of lack of provision of interpreters and reasons why (including face-to-face, telephone interpreting).
- Audit of documentation of provision/use of interpreter in medical files.
- Policies on consent include directions about the role of interpreters and family.
- Feedback from patients on the use of interpreters in decisions about treatment and care planning.
- Evidence of appropriate translations, signage, commonly used consumer/patient forms, education and audio visual materials, in languages other than English for predominant language groups utilising the service.
- Quality/risk management committee (s) develop initiatives to track miscommunication errors for CALD consumers/patients.
- Number of cases reported through 'adverse event' reports related to communication issues for CALD consumers/patients.
- Number of complaints lodged by CALD consumers/patients.
- Strategies in place to communicate with CALD consumers/patients even when the CALD demographics are low.
- Research is conducted into outcomes of CALD patient care needs (for example comparative studies between English Speaking and Non-English speaking patients regarding length of stay, emergency presentations, diagnostic tests, failure to attend appointments, evaluation of post consultation outcomes, etc.).

### **Standard 4: Inclusive practice in care planning is demonstrated, including but not limited to: dietary, spiritual, family, attitudinal, and other cultural practices**

#### **Measure 4.1**

- Numerator: Number of CALD consumers/patients who indicate that their cultural or religious needs were respected by the health service (as good and above)
- Denominator: Total number of CALD consumers/patients surveyed on the Victorian Patient Satisfaction Monitor (VPSM) or other patient satisfaction survey

#### **Measure 4.23**

- Policies and procedures for the provision of appropriate meals (vegetarian, Halal, Kosher, etc.) are implemented and reviewed on an ongoing basis.

#### **Sub-measures**

- Feedback from patients on the provision of information about their care and treatment is used to inform planning, development and review of services and support.
- CALD patient satisfaction data collected and analysed (VPSM and other).
- Consumer evaluation of cultural appropriateness of particular programs or services.
- Development of and/or use of suitable instruments for assessment (clinical diagnosis and treatment) incorporating cultural considerations used by medical, clinical and allied health staff.

**Standard 5: CALD consumer, carer and community members are involved in the planning, improvement and review of programs and services on an ongoing basis**

**Measure 5.1**

- CALD consumer membership and participation is demonstrated in the Community Advisory Committee (CAC) the Cultural Diversity Committee (CDC), or other specified structure.

**Sub-measures**

- Minutes of meetings show that the CAC/CDC or other specified structure has provided advice on planning and evaluation to the board (CAC) or executive (CDC) of the health service.
- CALD consumer and stakeholder involvement in performance review and quality improvement processes.
- Policies in place for facilitation of different degrees of participation from CALD consumers, carers and community members.

**Standard 6: Staff at all levels are provided with professional development opportunities to enhance their cultural responsiveness**

**Measure 6.15**

- Numerator: Number of staff who have participated in cultural awareness professional development
- Denominator: Total number of employed staff within the current two year period

**Sub-measures**

- Budget allocation for culturally responsive workforce development.
- Suggested training opportunities for staff (i.e. admission, reception, clinical staff, management, executive) on:
  - provision of language services and use of interpreters (at commencement of employment, as part of orientation program)
  - culturally responsive service delivery strategies
  - conducting organisational cultural assessments/audits
  - conducting cultural assessments to understand consumer/patient's explanatory model for health and illness
- Demonstrated post training staff evaluation on effectiveness and application of professional development.
- Human resources management policies and practices include cultural responsiveness references in position descriptions, performance review and promotion.
- Internal communication systems for sharing cultural diversity information and data are developed, maintained and periodically reviewed.

## Appendix F: Endnotes

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